

EXHIBIT G

In the Matter of:

Rysta Leona Susman, et al.

vs.

The Goodyear Tire & Rubber Company

Craig H. Lichtblau, MD

April 8, 2019



Court Reporting Solutions

Chicago, IL • 312.386.2000 • 800.868.0061

<p style="text-align: right;">25</p> <p>1 half out. At the time that I saw him, she told me 2 he didn't go back to any more hospital admissions. 3 I don't know what's happened since the time I saw 4 him 'til now. And that's clinically significant. 5 He's not suffering from status epilepticus, 6 pneumonias, seizures, urinary tract infections, 7 autonomic storming. I have no reason to reduce his 8 life expectancy more than four years. 9 Q. As you sit here today, you don't know what 10 care he's received since you last saw the patient; 11 is that true? 12 A. Well, I had a pre-depo conference with the 13 plaintiff attorney. My understanding is the 14 mother's taking care of him, the family. 15 Q. Okay. Are you aware of any admissions to 16 the hospital since you last saw him? 17 A. No, I'm not aware of it. I mean, maybe it 18 happened, but I'm not aware of it. 19 Q. Are you aware of anything that would make 20 his condition unstable between -- anything that 21 happened since you last saw him that would make his 22 condition unstable? 23 A. Nobody's made me aware of that. 24 Q. Would you flip to the third page of 25 Exhibit G for me.</p>	<p style="text-align: right;">27</p> <p>1 what happened, but I know what happened. What 2 happened was he reached -- he plateaued. He's doing 3 as good as he's going to get, what you've seen. And 4 the truth of the matter is, in traumatic brain 5 injury, the majority of your functional turn takes 6 place in the first six months. You can still 7 continue to improve a little bit another 18 months, 8 so you're 24 months out. The truth of the matter 9 is, there's no finish line to the treatment of 10 traumatic brain injury. But it's going to be very, 11 very subtle after 24 months. 12 Q. Do you agree -- do you have any reason to 13 dispute the fact that he had in fact plateaued? 14 A. Well, you know, I don't have an opinion 15 because that's not what I was asked to do. I wasn't 16 asked to really figure out if he received 17 appropriate care or not, because that would come 18 under appropriate care. 19 I was asked to -- looking at it, when I 20 went to see him, this is what I think he needs. I 21 didn't retrospectively look at whether he's 22 plateaued or not. 23 Q. Did you do any independent evaluation of 24 whether or not additional PT, OT or speech therapy 25 is necessary for this patient?</p>
<p style="text-align: right;">26</p> <p>1 A. Yeah. 2 Q. So the first paragraph in this -- on this 3 page refers to physical therapy that the patient 4 received from December of 2016 until June 8th of 5 2017. Do you see that? 6 A. Yes. 7 Q. It goes on to say, "The patient's mother 8 was informed they had done everything they could and 9 her son had plateaued. They did not feel that 10 ongoing therapy would improve his situation." 11 Did I read that correctly? 12 A. Yes. 13 Q. Tell me what you're trying to get across 14 in that sentence. 15 A. Well, I'm not trying to get across 16 anything. I'm just documenting this is history the 17 mother told me. But if you want to know -- forget 18 this case a second -- just how it works. If I admit 19 somebody to a rehab unit and I keep them there and 20 we're billing 1,200 to 1,500 dollars a day and 21 they've plateaued and I keep them there, it's 22 fraudulent billing. It would be called physician 23 overutilization. 24 Once he reaches MMI, they can't justify 25 keeping him there anymore. So she's telling you</p>	<p style="text-align: right;">28</p> <p>1 A. Yes. 2 Q. We'll get to that later. But what is the 3 basis of your opinions -- what is the experiential 4 or educational basis for your opinions on PT, OT and 5 speech therapy? 6 A. The date of the injury was 5/1/15. I saw 7 him on 6/9/17, and I thought one more year would be 8 beneficial, because he's transitioned home and it 9 would -- it's no longer in a coordinated inpatient 10 setting under close medical supervision. So to 11 transition him, I said three times a week for one 12 year for each discipline, one, two, three, and 13 that's it; that's all he gets, he's done. 14 Q. So you're looking at a different section 15 in your report -- 16 A. Yeah. 17 Q. -- but when you say three times a week for 18 one year and then PRN, that means as needed 19 afterwards? 20 A. Yeah, but the PRN doesn't count. 21 Economically it's not included. So it's three times 22 a week for one year, PT, OT and speech, really for 23 transition into the home. 24 Now, they wouldn't be coming into the 25 home. Hopefully, he would be in a situation where</p>

<p style="text-align: right;">45</p> <p>1 that --</p> <p>2 A. Yeah, but --</p> <p>3 Q. -- is set up?</p> <p>4 A. -- you have to realize, the problem with</p> <p>5 mortality tables is, it's the general population,</p> <p>6 all drinkers, all smokers, all risk takers; it's the</p> <p>7 whole group.</p> <p>8 Q. Right.</p> <p>9 A. Life expectancy is -- the definition of</p> <p>10 life expectancy -- well, let me clarify that.</p> <p>11 The statistical definition of life</p> <p>12 expectancy produced by statisticians, such as a</p> <p>13 Shavelle and Strauss, talk about, it's the average</p> <p>14 of the survival times of a specific patient</p> <p>15 population.</p> <p>16 What you can't do is walk in and say,</p> <p>17 because of this group, this particular patient is</p> <p>18 going to die at such and such a year. That gives</p> <p>19 you the crystal ball and it puts you on the God</p> <p>20 Squad. And it's speculation in a court of law. But</p> <p>21 what you can do is talk about groups of population.</p> <p>22 According to peer-reviewed published</p> <p>23 literature, this patient will have a four-year</p> <p>24 reduction in life expectancy due to the fact that</p> <p>25 he's got a severe traumatic brain injury, and I'm</p>	<p style="text-align: right;">47</p> <p>1 dementia. So I agree, there are increased risks for</p> <p>2 all those thing, but I can't say it's more probable</p> <p>3 than not that he's going to have them.</p> <p>4 Q. If he does have -- if he does have any of</p> <p>5 these -- would you consider these complications or</p> <p>6 something separate from that?</p> <p>7 A. Yeah, they're a complication of a</p> <p>8 traumatic brain injury, but if you have Parkinson's,</p> <p>9 you control it with medications. And dementia-type</p> <p>10 doesn't mean Alzheimer's.</p> <p>11 So I wouldn't say it's going to reduce his</p> <p>12 life expectancy anymore. I would just say it's</p> <p>13 going to make his life miserable.</p> <p>14 Q. So you don't see -- if you assume for the</p> <p>15 sake of argument that Mr. Loveland did experience</p> <p>16 traumatically-induced epilepsy, you see no drop in</p> <p>17 his life expectancy in the event that he does</p> <p>18 experience that complication?</p> <p>19 A. Well, no, it depends. It depends if he's</p> <p>20 getting appropriate aide and attendant care.</p> <p>21 Because if that's the case, then he would have to</p> <p>22 have RN and LPN level of care and they can put</p> <p>23 Diastat in his rectum, because they are allowed to</p> <p>24 pass meds, and they would have early detection and</p> <p>25 early intervention. However, if he doesn't have</p>
<p style="text-align: right;">46</p> <p>1 okay with that. I think that that's legitimate.</p> <p>2 Q. Do you think that his risk of dying in any</p> <p>3 given year would be increased, as opposed to the</p> <p>4 general population?</p> <p>5 A. No. I think that I would go by the</p> <p>6 literature, and specifically, the National Research</p> <p>7 Counsel Summary Golf War and Health, Volume 7,</p> <p>8 Long-Term Consequences of Traumatic Brain Injury,</p> <p>9 Washington D.C. This is the National Academy of</p> <p>10 Press 2008. They said, based on their research --</p> <p>11 and this is government funded. This is as good as</p> <p>12 it gets. They did this with our servicemen,</p> <p>13 veterans. They said, four years. I have no reason</p> <p>14 to disbelieve that, so that's what I'm going to go</p> <p>15 with. It's peer-reviewed, published, accepted.</p> <p>16 That's the best I can do.</p> <p>17 Q. The next paragraph in your -- on page 7 of</p> <p>18 Exhibit G, which is your summary report, goes on to</p> <p>19 identify some increased risks that Mr. Loveland is</p> <p>20 exposed to because of his TBI. Do you see that?</p> <p>21 A. Yes.</p> <p>22 Q. Can you identify for me what these</p> <p>23 increased -- what he's at an increased risk for?</p> <p>24 A. Yeah. Increased risk for traumatic brain</p> <p>25 induced epilepsy, Parkinsonism, Alzheimer's-like</p>	<p style="text-align: right;">48</p> <p>1 early detection and early intervention, well then,</p> <p>2 yeah, you can reduce his life expectancy, because</p> <p>3 you can die from seizures.</p> <p>4 Q. What about Parkinsonism?</p> <p>5 A. Well, that's not Parkinson's disease.</p> <p>6 Parkinsonism means that, you know, he has the</p> <p>7 shaking and the bradycardia slowness of gait and</p> <p>8 slowness of movement, masked face, yes.</p> <p>9 Q. If he ultimately suffers from that, would</p> <p>10 that impact his life expectancy?</p> <p>11 A. Probably not, not any more than the four</p> <p>12 years.</p> <p>13 Q. What about Alzheimer's-like dementia?</p> <p>14 A. Again, that would just make taking care of</p> <p>15 him more complicated.</p> <p>16 Q. But in your judgment, it wouldn't impact</p> <p>17 his life expectancy.</p> <p>18 A. Well, it's going to impact his life</p> <p>19 expectancy due to the fact that he's going to reduce</p> <p>20 it by four years.</p> <p>21 Q. You also go on to state that the brain</p> <p>22 injury that he suffered increases his potential to</p> <p>23 develop hydrocephalus in the future?</p> <p>24 A. Correct, but I can't swear to more</p> <p>25 probable than not. It's a possibility. And he has</p>

<p style="text-align: right;">49</p> <p>1 a shunt placed anyway, so probably not. That's in 2 the literature. I don't pick and choose out of 3 literature because that's not right. I go ahead and 4 print the whole thing, and that's in the literature. 5 But he has a VP shunt, so he's probably not going to 6 have that, because that's what the VP shunt is 7 treating right now. 8 Q. The last, I guess, additional risk that 9 you identify in this paragraph is, he's at a 10 lifetime risk for multiple organ system failure. 11 A. Yes. 12 Q. Can you describe that? 13 A. It was in the article. 14 Q. Okay. 15 A. You know, if he's on medications, then 16 you're at risk for complications with your liver or 17 complications with your kidney, because everything's 18 filtered -- all the blood is filtered by the liver 19 and the kidneys. 20 Q. Is it fair to say, that if he does suffer 21 from multiple organ system failure, that that would 22 in fact impact his life expectancy? 23 A. Yes, but that's a possibility, not a 24 probability. 25 Q. What about -- well, I'll go one at a time.</p>	<p style="text-align: right;">51</p> <p>1 costs for these items are based on -- then you list 2 five or six things. 3 So are these five and six things what you 4 rely on in formulating your continuation of care? 5 A. Yes, plus knowledge, training, clinical 6 practice experience, which exceeds over 130,000 7 hours, and the peer-reviewed published literature 8 backing up all my opinions. 9 And you'll notice I did speak to the 10 patient's treating neurologist and the patient's 11 treating primary care physician. We had a 12 conversation. And the neurologist actually faxed it 13 back and signed it, signed it 6/30/17. The primary 14 care physician never signed -- he didn't sign it and 15 send it back, so I assume that he was fine with what 16 exactly was said. 17 But, basically, these are my opinions. It 18 just so happens that the primary care physician and 19 neurologist agrees with my same opinions, because 20 this patient is catastrophically injured. 21 And this comports with the protocol that's 22 been peer-reviewed, published and accepted worldwide 23 that was authored by me. And that's why we do it 24 that way, to have accuracy at a premium. There's no 25 fluff and puff in the report. I don't have therapy</p>
<p style="text-align: right;">50</p> <p>1 Does traumatically induced epilepsy 2 increase his risk for being hospitalized? 3 A. It could increase risk, but it doesn't 4 meet legal threshold of more probable than not. 5 Q. Okay. Would your answer be the same for 6 Parkinsonism? 7 A. Yes. 8 Q. Would your answer be the same for 9 Alzheimer's-like dementia? 10 A. Yes. It's an increased risk probably 10 11 to 20 percent, but I can't say it's greater than 12 50 percent. That doesn't meet legal threshold. 13 Q. Okay. Same for hydrocephalus? 14 A. Well, I doubt that's going to happen 15 because he already has a shunt. 16 Q. And the same, the multiple organ system 17 failure? 18 A. Right. Very low probability. 19 Q. Before we move on, let's look at the last 20 page, page 8 of your summary report, which is 21 Exhibit G. 22 So you state that this patient's future 23 medical care, support services and durable medical 24 equipment are defined in the continuation of care 25 section of this report. This medical necessity and</p>	<p style="text-align: right;">52</p> <p>1 visits to Disney World, I don't have hyperbaric 2 oxygen, I don't have hippo therapy. I don't have 3 any fluff and puff. 4 What's in this report is written in such a 5 way, which I think is a medical necessity to keep 6 this patient as safe as possible. And to make sure 7 there's nothing far reaching in the report and to 8 make sure that there's no hocus pocus in the report, 9 you'll notice, when I write a PRN, it does not meet 10 legal threshold. So this cost is not included in 11 the economic analysis. So if you go to page number 12 2, basically everything is out where it says PRN. 13 And page number 3, that whole section, diagnostics 14 is out, when it says one time a year/PRN, or PRN. 15 And when you go to page number 4, I 16 dropped out 1 million to \$4 million -- or, I 17 shouldn't say, I drop out. I don't include 18 1 million to \$4 million worth of care, 'cause I do 19 make the speculative assumption in this court of law 20 that we live in the perfect world and he'll never 21 have a complication. So I don't include 1 million 22 to \$4 million worth of care. But let's say he does 23 have a complication, such as seizures, has to be 24 admitted, there's no money associated with the 25 admissions to the hospital.</p>

<p style="text-align: right;">57</p> <p>1 well, not die. 2 BY MR. HEDGER: 3 Q. So there's not a risk of, you know, 4 obtaining a staph infection from being admitted into 5 the hospital or other hospital? 6 A. There's always a risk, but it doesn't meet 7 legal threshold of greater than 50 percent 8 probability. 9 Q. Okay. 10 A. And remember, in my thing, it's always 11 risk versus reward. 12 And in the courtroom arena, in order for 13 me to say it under oath, it's got to be greater than 14 50 percent probability. 15 Q. While we have your old methodology in 16 front of us, let me just ask you a few questions so 17 we don't waste any time here. 18 So the third paragraph down, it says, "In 19 my medical opinion, that these costs do not take 20 into account the costs which are associated with 21 various complications." 22 A. Right. And that's in the section that I 23 had that I said, I'm not including 1 million and 24 \$4 million worth of care because I'm going to make 25 this speculative assumption in a court of law that</p>	<p style="text-align: right;">59</p> <p>1 think he needs because he's had a catastrophic brain 2 injury. Whether he's getting it, that's a 3 completely different set of circumstances. And I 4 haven't seen him in a year and a half, so I have no 5 knowledge. 6 Q. But at the time that you saw him, was it 7 your medical opinion that he needed to see a 8 neurologist? 9 A. Yes, he should be followed by a 10 neurologist. He's had a severe brain injury, he's 11 on -- let me see if he's on antiseizure medications. 12 I don't know what he's on. 13 He's on Prozac, Amantadine, a blood 14 thinner, Risperidone, Depakote, Tramadol, trazodone. 15 I mean, he should see a neurologist. 16 Depakote is an antiseizure medication. 17 He's getting 125 milligrams, four in the morning, 18 four midday and two at night. That can affect your 19 liver, your kidneys. It can also affect your blood 20 marrow. And your blood marrow is where your red 21 cells, your white cells and your platelets are built 22 and sent out into the bloodstream. He should be 23 monitored by a neurologist and a primary care 24 physician at a minimum. 25 Q. You have an asterisk by neurologist.</p>
<p style="text-align: right;">58</p> <p>1 we live in a perfect world and -- you know, and he's 2 not going to have any problem. 3 Q. But these are all complications that he is 4 at risk for? 5 A. Yeah. But, I mean, he's at risk, but it's 6 not -- doesn't meet anywhere near legal threshold. 7 (Interruption in the proceedings.) 8 BY MR. HEDGER: 9 Q. All right. Back to what we've marked as 10 Exhibit H. I assume the continuation of care 11 portion is not going to change? 12 A. No, it's not. And you'll notice the 13 cardiology, orthopedic surgeon, gastroenterologist. 14 There's no costs included in an economic analysis 15 because it's a PRN. The neurologist is two to four 16 times a year and PRN. The and PRN is not included. 17 It's only two to four times a year. But I'm not a 18 life care planner, I'm a medical doctor, and that's 19 why I write it this way. This is complete, but yet 20 follows the rules of the court by speculation. 21 Q. Do you know the last time -- let's start 22 with neurologist. Do you know the last time he saw 23 a neurologist? 24 A. I have no idea, but that's irrelevant. 25 What's relevant to me is this is what I</p>	<p style="text-align: right;">60</p> <p>1 A. Yeah. 2 Q. That refers to, I guess, something that 3 Dr. Morgan Laholt, who's -- was that his treating 4 neurologist? 5 A. Yes. In other words, I called him to 6 confirm the prices and confirm how often he wanted 7 to see him. 8 These are my opinions. It just so 9 happens, whenever I can get ahold of a treater to 10 confirm or deny, I will go ahead and do that to 11 accuratize this. That's part of my protocol, which 12 is different than a physician life care planner of 13 that crew out in Texas. 14 Q. Lots of anti-Texas talk today. 15 A. No, it's not. It's -- I believe it should 16 be done with a medical model, not a business model. 17 Q. I'm just joking. 18 A. Yeah. I like Texas. 19 THE WITNESS: Off the record. 20 (Discussion off the record.) 21 MR. HEDGER: Back on the record. 22 BY MR. HEDGER: 23 Q. All right. So we started out with the 24 neurologist. We're on page 1, continuation of care, 25 which is I think --</p>

<p style="text-align: right;">61</p> <p>1 (Interruption in the proceedings.) 2 (Marked for identification is Defense 3 Exhibit I.) 4 BY MR. HEDGER: 5 Q. Doctor, I've just been handed I guess a 6 folder that your office just brought in. Can you 7 identify that for the record? 8 A. Yes. That is the updated methodology page 9 and updated literature that I was talking about to 10 back up my opinions about hip fractures. 11 Q. Okay. Let's return to Exhibit H, which is 12 the continuation of care. 13 So, Dr. Laholt, you reference -- you have 14 an asterisk by neurologist you reference, that's per 15 your conversation with Dr. Laholt? 16 A. Yeah, that price comes directly from a 17 treater. 18 Q. Okay. So you're talking about the price? 19 A. Yes. 20 Q. Because Dr. Laholt recommended two to 21 three times a year and you recommend two to four 22 times a year? 23 A. Correct. 24 Q. So you disagree with him about -- a little 25 bit about the number of times per year?</p>	<p style="text-align: right;">63</p> <p>1 say, he gets sent to the emergency room because of 2 X, Y and Z, that's why it would be -- that's why 3 it's a range. 4 Q. Do you have a sense of -- can you weight 5 this one hundred to four hundred dollar per office 6 visit in any way, given the likelihood that he has 7 one of those complications? 8 A. No, because it's speculative. All I can 9 say is, Look, it's two to four times a year, it's 10 one hundred to four hundred. That's why I always 11 tell the economists, Do a range high to low. 12 Q. Speaking of that, did you talk to the 13 economist on this case? 14 A. I don't know who it was. 15 Q. Pettingill. 16 A. Probably, but I don't document it. I take 17 so many calls a day. But he knows -- I've worked 18 with him in the past and he knows how to do my 19 reports. He knows when it's a PRN and it's not 20 included. 21 Q. So you have no specific recollection of 22 talking to Pettingill about this particular report? 23 A. No, I don't remember. But if he says 24 under oath that we did, we probably did. 25 Q. Now let's go to the diagnostic tests.</p>
<p style="text-align: right;">62</p> <p>1 A. No, because it's a range of two to four. 2 Q. Okay. Which would include three? 3 A. Yeah, which would include three. 4 Q. Let's flip to the section, Diagnostic 5 Tests. 6 A. Yeah, that would be page No. 2. And it's 7 a moot point, because, look, it's, PRN, PRN, PRN, 8 which means it's not included. 9 Q. Okay. So let's jump up to medical care, 10 continued on that page, page 2? 11 A. Yeah, this ENT and the neurosurgeon is not 12 included. 13 Q. So the primary care and the urologist is 14 all we care about then? 15 A. Correct. 16 Q. So the primary care, you list the range of 17 100 to four hundred dollars, and that's per Chadd 18 Murray. 19 A. Correct. 20 Q. Is that the plaintiff's primary care 21 physician? 22 A. Yeah. Well, it was at that time. 23 Q. Okay. Does four hundred bucks for an 24 office visit seem high to you? 25 A. It is, but if he's complicated -- let's</p>	<p style="text-align: right;">64</p> <p>1 Let's just talk about the first one. 2 X-ray thoracolumbar? 3 A. Doesn't count. One time a year/PRN. All 4 of that, that whole section there, is not included. 5 Q. Not even the one time a year; I thought 6 that was normally included? 7 A. That one time a year/PRN, doesn't meet 8 legal threshold. So none of that's included in that 9 economic analysis. 10 Q. So anytime you have a one time a year or 11 two time a year slash PRN then it's not included? 12 A. Correct. 13 Q. What's the purpose of putting that into 14 the report then if it's not included? 15 A. Because I'm a medical doctor. I'm not a 16 life care planner. I'm not a physician life care 17 planner. 18 This is done as accurate as I can and I 19 follow the rules of the court; no speculation. But 20 it's there because realize that it's possible he 21 would need it, but I'm not saying it's probable. 22 Q. And that's the same for any one of these 23 where there's a slash PRN? 24 A. I agree. So really, like, page No. 4, all 25 of that is out; there's nothing included there.</p>